HIPAA AUTHORIZATION

THIS AUTHORIZATION OUTLINES WITH WHOM MEDICAL INFORMATION ABOUT YOU MAY BE SHARED.

Our Notice of Privacy Practices outlines how we may use or disclose your medical information on a regular basis. This Authorization is for situations not included in the Notice when you may want us to share your medical information with someone else, such as family members or your caregiver. This authorization will go into effect on the date signed and will remain in effect for a period of five years, at which point you will be requested to update this form. A revocation of disclosure may be made at any time and will apply to the date of the revocation going forward. The office must be notified to revoke any disclosures.

WHO MAY RECEIVE THIS INFORMATION

Name:_____ Relationship:_____

Information to be Disclosed:

[ ] Complete Health Record [ ] Financial Information [ ] Other (specify):_____

Name:_____ Relationship:_____

Information to be Disclosed:

[ ] Complete Health Record [ ] Financial Information [ ] Other (specify):_____

I understand that once disclosed to the individual(s) named above, Mountain Laurel Dermatology (MLD) cannot guarantee that the individual(s) will maintain the confidentiality of such information as described by law.

_____

Patient Name Date of Birth

_____

Signature of Patient or Authorized Representative Date

_____

Printed name of Authorized Representative and Relationship

Communication Consent

I authorize MLD to communicate with me via email, text, or phone call (carrier message and data rates may apply.) I consent to MLD's use of a third-party messaging system to contact me regarding pending, missed, or overdue appointments, balances due, lab results, and any other treatment, payment, or administrative matter. I acknowledge that texts are unencrypted and could be easily read by an unintended party during and after transmission. I acknowledge I can opt out of receiving these messages at any time by notifying MLD directly. No personal information will be sold or used for marketing purposes.

_____

Signature of Patient or Authorized Representative Date

Revised 12/2024